Correspondence

Disservice to the most needy!

I would be extremely concerned that patients with the major mental illnesses under Bohmer's standard care model would be classed as needing 'standard care' and would be handled by non-medical professionals.[1] To me, this is callous care and not standard care. It is a theoretically smart sounding concept, but, at a clinical level, most good clinicians would appreciate that just knowing the protocol and guidelines without knowledge of various other possibilities in the vast array of medical complexities is a dangerous practice. There is a clear difference between how a doctor diagnoses and attributes complaints to a cause compared with other professionals and these concepts are now being created only to undermine the role of a doctor in psychiatry.

What is further concerning is that the history and the future of research are never considered in these theoretical concepts. Research for these standard-care patients has come mostly from doctors who have closely worked with these patients day in and day out learning the subtleties of their presentations.

If research is to continue, doctors will have to work closely with these standard-care patients! This is a seriously concerning model to me.

1 Abed RT. Custom and standard care: implications for the future role of doctors in mental health. *Psychiatrist* 2010; **34**: 505–6.

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Why not patient feedback on psychiatric services?

We read with interest the article by Hansen *et al*,[1] which brings the important issue of patient satisfaction back on the agenda. We would, however, encourage our colleagues to go further and collect patient satisfaction data for psychiatric services routinely. This is especially important considering the current time of austerity and the fact that, when compared with other high-income countries, the UK scores badly on patient-centred care.[2]

Most trusts in the current market-driven National Health Service are using Health of the Nation Outcome Scales (HoNOS) as an outcome measure to assess the quality of service provided. Although we do not dispute the importance of getting validated data on improved patient outcome, this is a clinician-rated tool and as such it has the inherent issues of bias.

Most large organisations get feedback from customers, and the success of companies such as TripAdvisor and Amazon is based on the fact that customers regularly give feedback on their websites. Should we not be doing the same regarding the service we are providing? How else would we know what the patients expect from our service?

When considering service provision in times of fiscal austerity, we need to consider all our stakeholders, of which patients are the most important. When justifying our services to commissioners, we should also include the views of patients. We would go even further and suggest that patients could also inform us of how services could be cut in these difficult financial times.

1 Hansen LK, Vincent S, Harris S, David E, Surafudheen S, Kingdon D. A patient satisfaction rating scale for psychiatric service users. *Psychiatrist* 2010; **34**: 485–8.

2 The Commonwealth Fund. *Commission on a High Performance Health System*. The Commonwealth Fund, 2007.

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Home treatment teams and compulsory admissions – more information needed

Forbes *et al*[1] found that the absolute number of compulsory admissions increased after the introduction of an intensive home treatment team and a reduction in hospital beds. Tyrer *et al*[2] also described an increase in compulsory admissions after the introduction of home treatment teams. These findings raise concerns about the current policy of gatekeeping home treatment teams.

Looking at our own data, in the London borough of Wandsworth there were 151 compulsory admissions in the second quarter of 2008–2009, 119 compulsory admissions in the third quarter and 144 in the fourth quarter. In March 2009, there was a reduction of 6 in-patient beds, and in the first quarter of 2009–2010 there were 181 compulsorily admitted patients, which dropped to 151 in the second quarter and dropped again to 126 in the third quarter. The closure of 6 beds might well explain the increase in compulsory admissions in the first quarter of 2009–2010, but after 3 months the number of compulsory admissions dropped to the previous level.

A temporary increase in compulsory admissions after a reduction in hospital beds and the introduction of a home treatment team should be avoided if possible, but the consequences for service planning are far less severe than with a more permanent increase in involuntary admissions. Maybe with a larger reduction of in-patient beds the number of compulsory admissions would return to previous levels after a longer time period had passed.

1 Forbes NF, Cash HT, Lawrie SM. Intensive home treatment, admission rates and use of mental health legislation. *Psychiatrist* 2010; **34**: 522–4.

2 Tyrer P, Gordon F, Nourmand S, Lawrence M, Curran C, Southgate D, et al. Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4.

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